Sheffield University (J A Burton)
University of Minnesota Medical School (Claus A Pierach)
University of Wales College of Medicine (F N Porter)
Witwatersrand University (Kurt Schwarz)

**Last year I sent a questionnaire to the deans of the United Kingdom's 27 clinical medical schools about the administration of the Hippocratic oath. The table shows the results, which were not available when the decision to publish Irvine Loudon's letter of 6 August was taken.
T DELAMOTHE, *BMJ*

Administration of Hippocratic or similar oath to medical graduates in United Kingdom's 27 clinical medical schools

Clinical medical school	When/how oath administered
No oath of any sort	
Bristol University	Oxford University
Cambridge University	St Bartholomew's Hospital Medical College
King's College School of Medicine and Dentistry	St Mary's Hospital
The London Hospital Medical College	Southampton University
Manchester University	United Medical and Dental Schools of Guy's and St Thomas's Hospitals
Newcastle University	University College London
Nottingham University	
Hippocratic oath	
Charing Cross and Westminster	Dean reads oath to all new students on first day of medical school
Royal Free Hospital	Oath read out at graduation ceremony
St George's Hospital	Graduands repeat modern version of oath at degree ceremony
Declaration of Geneva	
Birmingham University	Students invited to sign
Leeds University	Dean reads at degree ceremony
Leicester University	Students read at degree ceremony
Liverpool University	Students take at degree ceremony
*Other**	
Aberdeen University	Newly qualified doctors affirm oath at graduation
Dundee University	Graduands affirm declaration read out by dean
Edinburgh University	Dean reads to the graduands at the degree ceremony
Glasgow University	Medical graduates' oath
Queen's University of Belfast	Graduands take before graduation
Sheffield University	Dean reads Sheffield affirmation
University of Wales College of Medicine	Graduates read pledge to which they have all subscribed before admission

*Sometimes referred to as the sponsio academica, oaths in this group are along the lines of: "I, ..., solemnly declare that as a Graduate of Medicine of the University of X, I will exercise my profession to the best of my knowledge and ability, for the good of all persons whose health may be placed in my care, and for the public weal; that I will hold in due regard the honourable traditions and obligations of the Medical Profession, and will do nothing inconsistent therewith; and that I will be loyal to the University and endeavour to promote its welfare and maintain its reputation."

The Hippocratic oath updated

Could boost credibility of doctors

EDITOR,—Eugene D Robin has done medicine a service by recasting the Hippocratic oath in a modern form.[1] His suggestions tackle many of the ethical principles (respect for autonomy, beneficence, non-maleficence, justice, and scope) lucidly discussed by Raanon Gillon.[2] I think, however, that two paragraphs are in danger of compromising the principle of autonomy—namely, the one relating to honesty with patients and the one starting, "I will do unto patients and their families only what I would want done unto me or my family." This could be avoided by explicitly stating respect for autonomy in terms of imparting information and undertaking procedures.

I also believe that there should be explicit mention of the need to relieve pain. To some extent this is encompassed in the seventh paragraph by the words "to cure when possible but to comfort always." However, as the provision of pain relief is still a large blind spot in medical practice, though central to the physician's role, I suggest that this paragraph should finish, "I will strive to cure when possible, to comfort always, and to do my utmost to relieve pain and suffering."

It would be a shame if Robin's suggestion remains only a box in a journal. Would the BMA or even the General Medical Council be interested in taking it up as a manifesto? At a time when patients' faith in their physicians is sometimes sorely tried it might give a much needed boost to doctors' credibility.

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1 Robin ED. The Hippocratic Oath updated. *BMJ* 1994;**309**:96. (9 July.)
2 Gillon R. Medical ethics: four principles plus attention to scope. *BMJ* 1994;**309**:184-8. (16 July.)

Surrogates' decisions in resuscitation are of limited value

EDITOR,—Eugene D Robin's updated version of the Hippocratic oath contains much with which we would agree.[1] In the fourth paragraph, however, he suggests that physicians should be bound by the wishes of their patients or, when the patient is incompetent to decide, the decision of family members.

We respect the right of patients to make informed decisions about their own care, but the degree to which that right should be transferred to surrogate decision makers is less clear. When patients have stated their wishes before becoming ill we will respect those wishes, but in Australia and the United Kingdom only a minority of patients will have made such a declaration. As doctors working in intensive care we are regularly confronted with the decision to withhold or withdraw life sustaining treatment, and whenever possible we discuss this with the patient. In most cases it is not possible to determine the patient's wishes, and we will then discuss the options openly and honestly with family members. We still strongly believe, however, that the ultimate decision to withdraw or withhold treatment lies with the medical and nursing staff caring for the patient, for two reasons. Firstly, the decision made by the surrogate is often the opposite of that which the patient would make.[2-4]

Secondly, surrogate decision makers often feel that they have been asked to decide whether their loved ones should live or die; this burden should not be placed on the shoulders of someone who is already under great stress.

The line between granting patient autonomy and abrogating responsibility may be very fine. In some instances where continued treatment is clearly futile families will ask that "everything possible" be done. Leaving aside the issue of inappropriate use of scarce resources, we believe that it is wrong to continue treatment when the only realistic outcome is an undignified high technology death. In almost all cases further discussion, explanation, and independent second opinion, if necessary, and the passage of time allow the family to come to terms with the inevitability of death. On rare occasions we have had families demand that we continue treatment even to the point of performing cardiopulmonary resuscitation when we have believed that this course was futile and, as there was no possible benefit to the patient, might even constitute assault. When we have been unable to resolve our differences with the family in such cases we have done what we considered to be in the patient's best interests and allowed him or her to die. Fortunately, such extreme cases are rare, but they underline the fact that the ultimate responsibility is ours.

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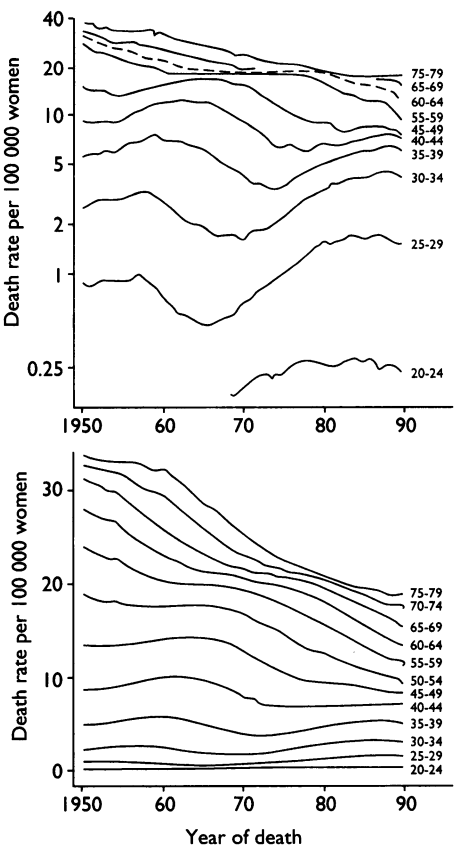
1 Robin ED. The Hippocratic oath updated. *BMJ* 1994;**309**:96. (9 July.)
2 Simpson K. Health care surrogate laws. *N Engl J Med* 1993;**328**: 1200.
3 Seckler AB, Meier DE, Mulvihill M, Crammer Paris BE. Substituted judgement: how accurate are proxy predictions? *Ann Intern Med* 1991;**115**:92-8.
4 Morgan R, King D, Prajapati C, Rowe J. Views of elderly patients and their relatives on cardiopulmonary resuscitation. *BMJ* 1994;**308**:1677-8. (25 June.)

Screening for cervical cancer

Graphs may mislead

EDITOR,—The cost-benefit ratio for cervical screening is less favourable in younger women than older women. Cervical cancer is less common in younger women, and the anxiety generated and the likelihood of unnecessary treatment or of an adverse effect on fertility are greater. Because screening young women may do more harm than good, those who advocate it should not mislead themselves or others about the facts.

Readers should compare the two graphs of death rate for cervical cancer by age shown in the figure.



Two graphs showing age specific death rates for cervical cancer, 1950-90, presenting same data but using different scales (reproduced from material supplied by P Sasieni of the Imperial Cancer Research Fund). Ages 50-54 are missing from the top graph for clarity of overall figure